RATES TO NURSING FACILITIES TAKE INTO ACCOUNT THE COSTS OF NURSING FACILITIES' COMPLIANCE WITH THE REQUIREMENTS OF §1919(b) [OTHER THAN PARAGRAPH (3)(F)], (c) and (d).

The payment rates to nursing facilities were adjusted, effective January 1, 1990, to take into account the costs of nursing facilities' compliance with the requirements of §1919(b) [other than paragraph (3)(F)], (c) and (d). In the rate years following that one-time adjustment, including the most recent rate year, which began July 1, 1996, costs associated with these requirements have been incorporated into each facility's per diem rate based on data submitted by each facility in its annual cost reports.

The costs of nurse aide training and competency are reimbursed as an expense necessary for the proper and efficient administration of the Medicaid program.

Minnesota has a long history of providing high quality long-term care services. Many state laws and rules regulate the type and amount of services that must be provided and included in the basic per diem rate. The case mix system utilized for nursing facility cost reimbursement is based on the individual needs of facility residents. Facilities are required to meet individual resident's needs and are reimbursed accordingly.

Under the Minnesota case mix reimbursement system, residents are classified in one of eleven categories (A-K). The "A" case mix classification is the lowest; persons classified at the "A" level require the least amount of physical care and assistance with activities of daily living. The "K" case mix classification is the highest; persons classified at the "K" level require the most assistance with activities of daily living. An "A" is given a weight of 1 (one unit of case mix); a "K" a weight of 4.12.

A resident day is a day for which nursing services are rendered and billable. A standardized day is the sum of the number of resident days in each resident case mix class (A through K) multiplied by the weight for that resident class. Each standardized day reflects 1.0 unit of case mix (that is, an "A" equals 1.0 unit of case mix, and a "K" equals 4.12 units of case mix). Nursing hours are all on-duty hours of nurses, nurse aides, orderlies, and attendants. The on-duty hours of the director of nursing for facilities with more than 60 licensed beds and the on-duty hours of any medical records personnel are not included in nursing hours. Vacation, holidays, sick leave, classroom training, and lunch hours are not included.

Pre-OBRA state requirements mandated that NFs (former SNFs and ICF-Is) provide a minimum of 2.0 nursing hours per resident day and 0.95 nursing hours per standardized day. In 1995, the average reported number of nursing hours per resident day for NFs was 2.96; the average reported number of nursing hours per standardized day for NFs is 1.21. This shows that facilities provide, on average, more nursing hours than required. The chart below illustrates the number of nursing

hours provided in reporting NFs for the period from October 1, 1994 through September 30, 1995 (the most recent available report year).

TOTAL NURSING HOURS - REPORT YEAR 1995*

Total productive nursing hours:	36,002,105
Total resident days[1] (all facilities):	12,144,752
Total standardized days[2]:	29,653,236

* Nursing facilities participating in the alternative payment project no longer report these statistics

AVERAGE AND MINIMUM NURSING HOURS REQUIREMENT

	Average	Minimum Required
Nursing hours per resident day	2.96	2.00
Nursing hours per standardized day (per unit of case mix)	1.21	0.95

1 Resident day: A day for which nursing services are rendered and billable.

2 Standardized day: The sum of the number of resident days in each resident case mix class (A through K) multiplied by the weight for that resident class. Each standardized day reflects one unit of case mix (that is, an "A" equals 1.0 unit of case mix and a "K" equals 4.12 units of case mix).

Payment rates in Minnesota nursing facilities have risen steadily in the last several years. The weighted average daily payment rate for the rate year beginning July 1, 1987 was $55.76, and the average daily payment rate for the period beginning July 1, 1996 was $99.35, an increase of 78 percent over nine years.

The inflation factor used in the calculation of payment rates for nursing facilities was the forecasted Data Resources, Inc. Consumer Price Index - all items (US City Average). This index is projected forward to account for anticipated economic pressures on such items as wages. The 21-month factor utilized for the rate year beginning July 1, 1996 was 4.99 percent for both care-related costs and other operating costs.

Because of the stringent requirements that were in effect prior to the implementation of the requirements of §1919(b), (c), and (d), many nursing facilities in Minnesota were able to meet those requirements with little additional cost. The norm of service provision and staffing levels in Minnesota nursing facilities was higher than pre-OBRA '87 federal and state requirements mandated. A detailed analysis of the differences between the pre-OBRA '87 facility licensure and certification requirements and the NF requirements, effective October 1, 1990, demonstrated that former skilled nursing facilities (SNFs) needed to make very few changes to comply with the October 1, 1990 federal regulations, and they consequently felt very little financial impact.

However, former intermediate care facilities (ICFs) had several areas where the pre-OBRA requirements were less stringent than the October 1, 1990 requirements, and the financial impact on those facilities, particularly the former freestanding ICF-IIs, was more significant. These facilities' higher costs were taken into account in determining the rate increases necessary to bring these facilities into compliance with the October 1, 1990 requirements.

Minnesota has a prospective payment system. Annually, except for facilities with contract rates, payment rates are calculated based on historical costs reported by facilities. There is a delay between the actual expenditures and the inclusion of those expenditures in payment rates. [Since July 1, 1995, nursing facilities which have received approval to contract with the State for their services have had an alternative rate-setting methodology -- the prior year's rate, plus inflation (CPI-U)]. Because of this prospective rate-setting method, it was preferable to provide up-front rate adjustments for the increased costs of meeting the OBRA '87 requirements in order to lessen the financial impact of the changes on providers.

To enable nursing facilities to meet OBRA requirements, the reimbursement rates were adjusted as of January 1, 1990. This provided nursing facilities with nine months of increased rates to upgrade their staffing and operations prior to the effective date of the new requirements. These adjustments were in effect for 18 months, until June 30, 1992. This allowed the inclusion of the increased costs in the reporting year that began October 1, 1990 and which ended September 30, 1991. The costs in the September 30, 1991 cost report were reflected in the July 1, 1992 rates, which became effective immediately after the expiration of the one-time OBRA rate adjustment on June 30, 1992. Additional incurred facility costs that can be included in per diem rates are allowable up to the established limits.

certification standards, and the OBRA 87 certification standards that, for the most part, took effect October 1, 1990.

As the chart indicates, there were very few federal certification regulations that were not already covered in state licensure statutes or rules for nursing homes and boarding care homes. Some differences existed between state licensure standards for boarding care homes (formerly ICF-IIs) and the new certification standards. However, the majority of nursing facilities in Minnesota already met most of the OBRA-related certification requirements.

As stated earlier, nursing homes and boarding care homes in Minnesota have historically provided a high level of services. Some facilities formerly certified to provide ICF level of care provided nursing staffs at the SNF level. Other facilities provided extensive initial and in-service training to ensure staff knowledge of service provision for a specific resident population. Some facilities provided extensive social services programs. Details of the differences between former state certification requirements and the OBRA certification requirements are discussed below.

ADMINISTRATION
All facilities are required to have a licensed nursing home administrator, whether they were certified to provide SNF services or ICF services. Consequently, all nursing facilities in Minnesota already met this requirement.

MEDICAL DIRECTION
SNFs were required to have a medical director. Some ICFs needed to retain the services of a medical director if they did not already have one. Cost calculations are provided later in this document.

DENTAL SERVICES
All licensed nursing homes and ICF-IIs were required to provide dental services for residents "appropriate to their needs". These services were and continue to be billed separately from the nursing facility per diem.

NURSING SERVICES
SNF facilities were already required to staff at the OBRA nursing levels (24 hours per day licensed nursing coverage; eight hours per day, seven days per week RN coverage). ICFs needed to increase their professional nursing coverage to meet the OBRA

requirements. The specific methodology for calculating the necessary increases is discussed later.

PHYSICIAN SERVICES
All facilities were required to have provisions for emergency physician services and advisory care. All residents were required to be under the care of a physician. The Requirements for Participation, as listed in the February 2, 1989 Federal Register, tighten the regulations regarding physician visits in nursing facilities for certification and recertification of appropriateness of stay. This requirement, however, has not increased costs to facilities, since physician visits are billed separately from the nursing facility per diem.

OUTSIDE RESOURCES
All certified facilities were required to have written agreements with any outside individual or organization providing resources or services used in the facility. This requirement did not increase costs to facilities.

DIETARY
State licensure regulations for dietary services were generally more stringent than the new OBRA 87 requirements. The OBRA 87 requirements empowered residents by accommodating their likes and dislikes, their customs, and previous dietary habits. In Minnesota, the stringent Residents' Bill of Rights and the active Resident Councils ensured that these measures were already met by facilities.

MEDICAL RECORDS
All licensed and certified facilities were required to provide for an accurate, confidential medical record-keeping system. This requirement did not increase costs to nursing facilities.

PHARMACY SERVICES
Facilities licensed as nursing homes (SNFs and ICF-Is) were required to conduct a quarterly review of medications. The OBRA regulations now mandate a monthly review be conducted by an independent pharmacist. This was an entirely new requirement for freestanding ICF-IIs and requires the acquisition of a pharmacy consultant for some SNFs, ICF-Is, and ICF-IIs.

INFECTION CONTROL
Licensing regulations have required nursing homes and boarding care homes to develop procedures for providing an infection-free (aseptic) environment. SNFs were required to have an infection

control committee. ICFs (Is and IIs) needed to implement an infection control committee if they did not already have one.

RESIDENT FUND ACCOUNTING
The State's licensing standards and the OBRA 87 requirements regarding resident fund accounting were almost identical. The major difference was the amount of money that must be deposited in a banking institution: the State had required that personal finances accepted by the nursing home in excess of $150 be deposited into an interest-earning account, and the OBRA 87 certification regulations required that personal funds in excess of $50 be deposited into a financial institution. This was a new requirement for ICF-IIs.

ACTIVITIES
Minnesota had required an extensive activities program be incorporated into the resident care plan, designed to meet the needs of each individual resident. The OBRA certification requirements for NFs spoke to the need to address the physical, mental, and psychosocial well-being of the resident. No change in costs to facilities was expected.

UTILIZATION REVIEW / QUALITY ASSESSMENT AND ASSURANCE
As of October 1, 1990, NFs were no longer required to have a utilization review (UR) committee. Many of the responsibilities of the UR committee have become the responsibility of the quality assessment and assurance (QAA) committee. In fact, many of the same staff assigned to the UR committee were assigned to the QAA committee. Little or no change in costs to facilities was expected.

SOCIAL SERVICES
The former certification standard required facilities to provide or arrange for social services. The OBRA standards stated that NFs must provide social services staffing at 1.0 FTE if the facility has 120 or more beds. Some ICF-IIs did not have an employee assigned specifically to social services; those facilities needed to add staff time for social services.

SPECIALIZED REHABILITATION SERVICES
SNFs, ICF-Is, and attached ICF-IIs were required to have rehabilitation programs and ongoing staff training in rehabilitation procedures. Freestanding ICF-IIs generally did not have specialized rehabilitation programs, because their licensure status did not allow them to admit residents needing that level of care. The additional nursing staff enabled the

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RESIDENT ASSESSMENTS
Minnesota has had a case mix reimbursement system in effect since 1985. Since that time, there have been at least two assessments per year completed on each nursing home and boarding care home resident. All residents are currently assessed upon admission. Additional assessments are required approximately five days after hospitalization and again 30 days after hospitalization.

In addition to the case mix assessments, facilities complete assessments when resident care planning is done. A new requirement for certification under OBRA was the comprehensive assessment using the Minimum Data Set; it was expected that it would take more time to complete the new form. The State intends to combine the two processes as much as possible, but this requirement was expected to increase costs to some facilities.

RESIDENT CARE PLANS
The State required a review of resident care plans every 30 days. The old and the new certification requirements mandated a quarterly review. Facilities were not expected to experience any cost increases.

SUMMARY
There were relatively minor differences between Minnesota's former facility licensure and certification requirements for SNFs and ICFs and the new federal requirements for NFs effective October 1, 1990. Where differences did exist, NFs have been able to modify their operations with a minimum of inconvenience to residents and staff.

A DETAILED ANALYSIS OF THE COST INCREASES THE STATE ANTICIPATED WOULD BE INCURRED BY NURSING FACILITIES IN MEETING EACH OF THE NEW REQUIREMENTS. THIS ANALYSIS INCLUDES THE METHODOLOGY USED BY THE STATE TO MAKE THE REQUIRED ESTIMATE, THE SPECIFIC COST DATA USED, AND THE EXPECTED IMPACT ON THE COST INCREASES OF ANY FACILITY WAIVERS THE STATE MAY GRANT UNDER § 1919(b)(4)(C)(ii).

A majority of Minnesota nursing facilities already met most of the OBRA 87 mandates and the February 2, 1989 Requirements for Participation because of the stringent state statutes and rules in existence prior to the enactment of OBRA 87. The State conducted a detailed analysis of the cost increases that would be incurred by NFs to meet each of the new requirements.

Because there were obvious differences between the state licensure and certification requirements and the new federal regulations, rate increases were provided in these areas:

- 24-hour licensed nursing coverage and seven days per week, eight hours per day RN coverage for former ICF-Is and ICF-IIs,
- Certified boarding care home (former ICF-IIs) upgrades, and
- The few new federal requirements for NFs that were more stringent than those required in Minnesota.

A. Analysis of nurse staffing coverage (in former ICF-Is and ICF-IIs).

Former SNFs already met the new OBRA 87 requirements for 24-hour licensed nursing coverage and eight hours per day, seven days per week RN coverage. A number of the former ICF facilities did not meet those nursing requirements and needed to increase their nurse staffing coverage.

Because each ICF chose its own way to meet state licensure requirements for nurse staffing, it was determined that nurse staffing adjustments would have to be decided individually. Facilities needed an increase only for those professional nursing hours for which they did not staff. For example, if an ICF did not staff an RN on weekends, it would require a rate increase for RN coverage only for the weekend. A formula was established to determine the increase each ICF would require to raise its nurse staffing levels to meet the new OBRA requirements. This formula provided for an incremental increase based on the facilities' costs for the report year 1988 (the most recent available data at that time), adjusted for inflation.

The annual cost reports filed with the Department of Human Services were reviewed to determine how many additional professional nursing hours or RN hours a facility needed in order to bring its nurse staffing levels into compliance with the new OBRA requirements. These additional hours were utilized to calculate the adjustment.

Salary information was obtained from the Minnesota Salary Survey of Hospitals and Nursing Homes, prepared by the Minnesota Department of Jobs And Training for 1987. It was

assumed that the ICFs already provided enough nursing hours, since state requirements mandated 24-hour staff supervision in these facilities, although those nursing hours may not have been provided by the right type of staff required in the 1990 regulations. It was assumed, therefore, that in each case, an RN or LPN would replace a nurse aide, whose salary was already included in current payment rates. Only the additional cost above the nurse aide's salary was included in the calculation.

The multipliers ($4.55 and $9.30) were calculated as follows:

We used the statewide salary at the 75th percentile for the RN and LPN job classifications and the statewide salary at the 50th percentile for nurse aides. This allowed the facilities extra range in the salary cost increases between nurse aides and nurses. Using these statewide salary figures, the difference between the 50th percentile nurse aide salary and the 75th percentile LPN salary was found to be $4.55, and the difference between the 50th percentile nurse aide salary and the 75th percentile RN salary was found to be $9.30. The hourly differential was then multiplied by the number of hours needed on an annual basis to comply with the new regulations (8760 hours for professional nurse coverage and 2920 hours for RN coverage). This was adjusted upward by 5 percent to account for inflation and then again by 50 percent to account for the cost of fringe benefits, payroll taxes and replacement workers during vacation and sick leave. The resulting cost for each facility was divided by resident days in order to translate the aggregate facility cost into a per diem for rate setting purposes.

B. Analysis of the cost increases which were to be incurred by certified freestanding boarding care homes (former ICF-IIs).

In addition to the adjustment to increase nurse staffing hours, certified freestanding boarding care homes (ICF-IIs) were provided a rate adjustment to cover other cost increases due to OBRA 87 requirements. Those freestanding ICF-IIs were required to submit estimates of their increased costs due to the OBRA 87 requirements in order to receive an individualized rate adjustment. The freestanding ICF-II rate adjustments were based on the specific cost increases for each of those facilities.